Birth Parent Updated Medical History

OFFICIAL USE ONLY	
CERTIFICATE NUMBER	
DATE RECEIVED	
DATE ISSUED	

Please ***PRINT (in black ink only)*** and complete as many items as known, required items are marked (*required)

Name of Child on original birth record: _____
First name Middle name Last name (***REQUIRED**)

City/Town of Birth: Hospital:

Date of Birth: Sex: ☐ Female ☐ Male
Month Day Year (***REQUIRED)**

Mother's name (as shown on child's birth record)

Person completing this form is: ☐ Birth Mother ☐ Birth Father

Please indicate if information is unknown ("unk") or not available ("N/A").

MEDICAL CONDITIONS OF CHILD'S BIOLOGICAL FAMILY

Mother's Family and Father's Family

*Please list relationship to child; e.g., parent, grandparent, aunt, uncle, sibling.

Condition	Mother's Family*	Father's Family*	Comments (if condition resulted in death, note here)
1. Respiratory			
Allergies			
Asthma			
Bronchitis			
Emphysema			
Tuberculosis			
Cystic Fibrosis			
Other			
2. Gastrointestinal			
Ulcers			
Inflammatory Bowel			
Cleft lip or palate			
Other			
3. Cardiovascular			
High blood pressure			
Heart attack			
Stroke			
Congestive heart failure			
Atherosclerosis			
Heart rhythm abnormality			
Congenital heart defect			
Other			